The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-258-6534. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-258-6534 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$400 per individual / $800 per family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes: Physician office visits, routine mammograms, other specified wellness benefits, the first $200 incurred within 72 hours after an accident and all charges incurred at the Operators' Health Center.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. $100 per visit to a hospital emergency room unless admitted to the hospital. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$2,000 per family for medical; $4,550 per person/$9,100 per family for prescription drugs.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Precertification penalties, premiums, balance-billing charges and health care this plan doesn't cover, such as non-emergency health care charges received from an out-of-network provider.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.welcometouhc.com/uhss or call 1-800-258-6534 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. The plan excludes out-of-network charges except in limited circumstances. Thus you will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance. (No charge if treated at the Operators' Health Center.)	Not covered	Not subject to deductible. First $200 incurred 72 hours following an accident paid in full. Out-of-network providers covered at in-network level if you live out-of-area (50 miles from nearest qualified network provider).
	Specialist visit	15% coinsurance	Not covered	Maximum annual benefit of $500 for treatment by a chiropractor. Chiropractic benefits are limited to x-rays and spinal manipulations only. Also, see above.
	Preventive care/screening/ immunization	No charge	Not covered	The following services are covered, and are not subject to the deductible: routine colonoscopies for employees and spouses age 50 or older once every 5 years, and, for all covered individuals, routine exams, immunizations, pap smears, audiograms, PSAs and mammograms. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance. (No charge for services received at the Operators' Health Center.)	Not covered	Not subject to deductible if performed in conjunction with a physician's office visit. First $200 incurred within 72 hours following an accident paid in full. Out-of-network providers covered at network level if you live out-of-area (50 miles from nearest qualified network provider). Additionally, out-of-network lab and x-ray services will be covered at the in-network level if you utilize a network physician.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Imaging (CT/PET scans, MRIs)	15% coinsurance	Not covered	The first $200 incurred within 72 hours following an accident is paid in full. Out-of-network providers are covered at the network level if you live out-of-area (50 miles from the nearest qualified network provider).
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling 1-800-228-3108.	Tier 1 drugs (Generic)	$5 copay 30 day supply/ $10 copay 90 day supply	Not covered	Supply limit of 30 days retail / 90 days mail order. Coverage for acid reflux medication or drugs that are available over-the-counter are excluded, unless otherwise covered pursuant to applicable law.
	Tier 2 drugs (Brand)	$50 copay 30 day supply/$100 copay 90 day supply	Not covered	See above. The use of Tier 2 drugs instead of Tier 3 will help reduce your out-of-pocket costs.
	Tier 3 drugs (Brand)	$50 copay 30 day supply/$100 copay 90 day supply	Not covered	See above. Many Tier 3 drugs have lower cost options in Tier 1 or Tier 2.
	Specialty drugs	30% coinsurance	Not covered	Certain approved specialty drugs may be provided and administered by a network physician, in which case they are paid as medical benefits – 15% coinsurance and subject to the deductible.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance. (No charge for services received at the Operators' Health Center.)	Not covered	The first $200 incurred within 72 hours following an accident is paid in full. Out-of-network providers are covered at the network level if you live out-of-area (50 miles from the nearest qualified network provider).
	Physician/surgeon fees	15% coinsurance. (No charge for services received at the Operators' Health Center.)	Not covered	See above.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance (But see the Limitations)	Subject to the $100 emergency room deductible. The first $200 incurred within 72 hours following an accident is paid in full. Out-of-network charges are subject to in-network benefit for emergency situations. Participant cost share will be the same for all emergency care.
	Emergency medical transportation	15% coinsurance	15% coinsurance (But see the Limitations)	The first $200 incurred within 72 hours following an accident is paid in full. Air ambulance covered up to maximum amount allowed by Medicare. Out-of-network charges are subject to in-network benefit for emergency situations. Participant cost share will be the same for all emergency care.
	Urgent care	15% coinsurance. (No charge for services received at the Operators' Health Center.)	Not covered	First $200 incurred within 72 hours following an accident paid in full. Out-of-network charges are subject to in-network benefit for emergency situations. Participant cost share will be the same for all emergency care.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	Not covered	Hospital stays must be pre-certified. Call 1-877-211-6452 to pre-certify. Out-of-network providers covered at network level if you live out-of-area (50 miles from nearest qualified network provider). Additionally, out-of-network ancillary providers (anesthesiologists, radiologists, pathologists, lab services) will be covered at the in-network level if you utilize a network facility.
	Physician/surgeon fees	15% coinsurance	Not covered	Out-of-network providers covered at network level if you live out-of-area (50 miles from nearest qualified network provider).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance. (No charge for services received at the Operators' Health Center.)	Not covered	Out-of-network providers covered at network level if you live out-of-area (50 miles from nearest qualified network provider).
	Inpatient services	15% coinsurance	Not covered	See above. Additionally, out-of-network ancillary providers (anesthesiologists, radiologists, pathologists, lab services) will be covered at the in-network level if you utilize a network attending physician and facility.
If you are pregnant	Office visits	15% coinsurance	Not covered	**Coverage is provided for employees and spouses only.** Out-of-network providers covered at network level if you live out-of-area (50 miles from nearest qualified network provider).
	Childbirth/delivery professional services	15% coinsurance	Not covered	See above. Additionally, out-of-network ancillary providers (anesthesiologists, radiologists, pathologists, lab services) will be covered at the in-network level if you utilize a network facility.
	Childbirth/delivery facility services	15% coinsurance	Not covered	Out-of-network providers covered at network level if you live out-of-area (50 miles from nearest qualified network provider).
If you need help recovering or have other special health needs	Home health care	15% coinsurance	Not covered	Out-of-network providers covered at network level if you live out-of-area (50 miles from nearest qualified network provider).
	Rehabilitation services	15% coinsurance	Not covered	See above.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	Not covered	Not covered	None
	Durable medical equipment	15% coinsurance	Not covered	See above.
	Hospice services	15% coinsurance	Not covered	See above.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Once every 24 months.
	Children's glasses	No charge	No charge	Once every 24 months.
	Children's dental check-up	No charge	No charge	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Gene therapy
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Weight loss programs, excluding screening and counseling

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform, or contact the office of the plan at 1-800-258-6534.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-258-6534.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$400**
- **Specialist *[cost sharing]*** **15%**
- **Hospital (facility) *[cost sharing]*** **15%**
- **Other *[cost sharing]*** **15%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$5
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$2,066**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$400**
- **Specialist *[cost sharing]*** **15%**
- **Hospital (facility) *[cost sharing]*** **15%**
- **Other *[cost sharing]*** **15%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$660
Coinsurance	$253
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$1,335**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$400**
- **Specialist *[cost sharing]*** **15%**
- **Hospital (facility) *[cost sharing]*** **15%**
- **Other *[cost sharing]*** **15%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$100
Coinsurance	$345
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$845**

The plan would be responsible for the other costs of these EXAMPLE covered services.